RIte Share Employer Application

Please check one:	**Date of Application:**	**Type of Company:**	**Optional:**
❑ New application ❑ Revised application	_____/_____/____	❑ Corporation ❑ Partnership ❑ Sole proprietorship	Total employees: _____ Total full-time: _____

Company Information:

Legal Name of Firm: _____

DBA Name of Firm: _____

Federal Tax ID #: _____

R.I. Tax ID # (different from federal): _____

Contact Name: _____Title:_____

Company Name (on statements): _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Do you use e-mail regularly?_____

Telephone: ( ) _____ Fax: ( ) _____

If you have more than one service location, please see reverse.

Health Insurance Information Health Plan Option 1

Health Plan Name: _____ **Group Number**:_____

Renewal Date: _____ **Is this a Section 125 plan?** _____

Plan Coverage	**Census** (# of employees enrolled)	**Monthly Premium** (per employee)	**Employer Monthly Contribution Amount ($)**	**Employee Monthly Contribution Amount ($)**
Employee Only				
Employee and Child(ren)				
Employee and Family				
Part-time employees**				

**Currently, the payment information system DHS uses does not have the capacity to pay *multiple* rates to employers for several different classes of part-time employees. If you charge more than one rate for health insurance for part-time employees, we will be unable to accommodate payment for those rates at this time.

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Health Insurance Information Health Plan Option 2

Health Plan Name: _____ **Group Number:**_____

Renewal Date: _____ **Is this a Section 125 Plan?** _____

Plan Coverage	Census (# of employees enrolled)	Total Monthly Premium (per employee)	Employer Monthly Contribution Amount ($)	Employee Monthly Ccontribution Amount ($)
Employee Only				
Employee and Child(ren)				
Employee and Family				
Part-time employees**				

Effective Date of Participation:

The effective date for employer participation in RIte Share is normally the day the Employer Agreement is signed. Any other effective date will require written agreement between the employer and the Department of Human Services.

Multiple Service Locations

Name of company Address

_____

_____

_____

_____

PLEASE REMEMBER TO ATTACH TO THIS FORM:

- ✓ A *summary of benefits* for every health plan offered, including information on co-payments
- ✓ A signed *RIte Share Employer Agreement*
- ✓ A copy of your *employee enrollment communications*
- ✓ A completed *Rhode Island Medical Assistance Program Authorization for Direct Deposit.*
- ✓ A voided check or savings deposit slip for the appropriate bank account
- ✓ Your broker/agent:_____ Telephone:_____

MAIL TO: Employer Contact Unit, RI DHS, 600 New London Avenue, Cranston, RI 02920.

For ECU Use Only:
Provider Code #083 Carrier Code_____ Effective Date:_____ End Date:_____
Individual _____ Employee + Child _____ Family _____ Part-time _____

For ECU Use Only:
Provider Code #083 Carrier Code_____ Effective Date:_____ End Date:_____
Individual _____ Employee + Child _____ Family _____ Part-time _____